NEW REQUIREMENTS FOR BENCHMARK BENEFIT PLANS
Effective July 1, 2010

On April 30, 2010 CMS published the Final Regulation on State Flexibility for Medicaid Benefit Packages which codifies section 1937 of the Social Security Act (Benchmark Benefit Plans) by adding to 42 CFR part 400 a new Subpart C, consisting of §440.300 through §440.390. This final rule becomes effective on July 1, 2010.

This rule provides States guidance on implementing benchmark and benchmark-equivalent benefit plans. It incorporates changes made to §1937 by CHIPRA as well as changes made in response to public comments. The following is a summary of major changes that States must now comply with:

§440.305 Scope
Prior to submitting a State plan amendment to establish a benchmark/benchmark-equivalent benefit plan or an amendment to substantially modify an existing benchmark/benchmark-equivalent benefit plan a State must have provided the public with advance notice of the amendment and reasonable opportunity to comment with respect to such amendment, and have included in the notice a description of the method for assuring compliance with full access to EPSDT services and the method for complying with the Indian/Tribal consultation requirements of section 5006(e) of ARRA.

§440.320 State plan requirements: Optional enrollment for exempt individuals

- When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State must:
    - Effectively inform individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State plan coverage, and describe the process for disenrolling.
    - Must inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and provide a comparison of how the benchmark plan differs from the standard State plan benefits.

- The State must document in the exempt individuals eligibility file that:
    - The individual was informed in accordance with this section prior to enrollment,
    - The individual was given ample time to arrive at an informed choice,
    - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- Enrolled individuals - for individuals the State determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State must inform the individual they are now exempt and the State must comply with all requirements related to voluntary enrollment.

- Disenrollment Process – State must promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and must have in place a process that ensures exempt individuals have access to all standard State plan services while the disenrollment request is being processed.

- The State must maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

§440.345 EPSDT Services

- The State must assure access to EPSDT services through benchmark/benchmark-equivalent plans or as an additional benefit provided for any child under 21. (SPA required)
- Any additional EPSDT benefits not provided by the benchmark/benchmark-equivalent plan must be sufficient so that in combination with the benchmark/benchmark-equivalent plan these children have access to the full EPSDT benefit.

- State must include in the State plan a description of how the additional benefits will be provided, how access to additional services will be coordinated and how beneficiaries and providers will be informed of these processes. (SPA required)

§440.380 Delivery of benchmark and benchmark-equivalent plans through managed care entities

States must comply with all managed care regulations at 42 CFR 438 if benchmark/benchmark-equivalent coverage is provided through a managed care entity.

§440.390 Assurance of transportation

States are required to assure necessary transportation to and from all covered medical services for individuals enrolled in benchmark/benchmark-equivalent benefit plans, as required under §431.53. (SPA)

Note: With publication of the final regulation, States submitting new benchmark benefit SPAs or amendments to approved benchmark benefit SPAs should be requested to use the new draft benchmark preprint currently undergoing OMB review.

AFFORDABLE CARE ACT REQUIREMENTS (ACA) - EFFECTIVE MARCH 23, 2010

- Services provided to newly eligible adults with incomes below 133% FPL must consist of benchmark or benchmark-equivalent coverage even if the state has not elected to provide benchmark coverage, unless the individual is exempt from mandatory enrollment in a benchmark/benchmark-equivalent plan.

- Benchmark benefit coverage for all enrollees must include family planning services and supplies and comply with mental health parity.

- Benchmark-equivalent coverage must include prescription drugs, mental health services and comply with mental health parity.

- Additional guidance on mental health parity will be forth coming.

- CMS will be publishing an additional final rule to include the changes made by ACA that became effective March 23, 2010.